SAFE Medicine®
Protect Yourself from Medication Errors
The Institute for Safe Medication Practices
Volume 3 Issue 1 January/February 2005

But the doctor said Dulcolax!

Pharmaceutical companies that make medicines know that well-known brand names can help people recognize their products. Take Anacin, for example. Everyone knows that Anacin is aspirin. But is it always aspirin? There's another medicine that clearly lists "Anacin" on the label, but it's acetaminophen. Sometimes, a well-known brand name is used as part of the name for a new medicine that contains a totally different medicine. This can lead to mistakes like the one described below.

A man needed to prepare for a colonoscopy (a procedure to examine the bowel). His doctor gave him written instructions to take two tablets of "Dulcolax" each day for 2 days before the procedure. At the pharmacy, the man bought a bottle of medicine with "Dulcolax" on the label. He didn't realize that there are actually several different medicines called Dulcolax. One is docusate sodium, which is a stool softener. Its official brand name is Dulcolax Stool Softener, but the most recognizable part of the label is the word Dulcolax. The more familiar Dulcolax medicine contains bisacodyl, a laxative. This is officially called Dulcolax Laxative. Again, Dulcolax is the main word you see on the label (see photo). The doctor wanted the patient to take the laxative, but he bought the stool softener.

These two Dulcolax products (left-bisacodyl; right-docusate) are certain to be confused.

The man's son, a pharmacist, realized his father had bought the wrong medicine. Taking a stool softener is not the right way to prepare for a colonoscopy. Without taking a laxative first, the procedure would not be successful and would have to be repeated. When the son went back to the pharmacy to purchase the correct product, he saw that both the laxative and the stool softener Dulcolax products were sitting side-by-side on the shelf.

Always read the label fully to find what medicines (active ingredients) are in the product you are buying. If you have questions, ask your pharmacist. Even if it's a familiar brand name, the medicine may not contain what you think it does!

60 second safety tip

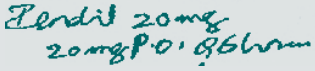
■ **Check for a label.** Your pharmacy may provide you with some prescription medicines still in their original boxes. These include ointments and creams, asthma inhalers, certain eye and ear drops, and even pills. Your pharmacist may then place a label with directions for taking or using this medicine on the *outside* box, not on the medicine container inside. If you throw away the box, you no longer have the directions. The label also has your doctor's name on it, and the pharmacy's phone number and continued on page 2

Brand name medicines appear in green; generic medicines appear in red.

Lessons in *handwriting*

It's no secret that many doctors have poor handwriting. While we sometimes joke about the difficulty in reading doctors' scrawl, it's no laughing matter. In fact, it can lead to deadly mistakes.

In 1999, one example quickly made the headlines. A cardiologist (heart doctor) had given a middle-aged man a handwritten prescription for 20 mg of Isordil (isosorbide) to be taken every 6 hours. The man needed this medicine to prevent episodes of heart pain that could lead to a heart attack. However, the doctor's handwriting was hard to read (see photo), and the purpose of the



medicine was not on the prescription. A pharmacist misread Isordil as Plendil (felodipine), a medicine used to treat high blood pressure. The man suffered a heart attack after taking high doses of Plendil every 6 hours for 1 day, and not taking Isordil as prescribed. He died a few days later.

This case made national news. It was the first time a doctor had been sued successfully for writing an unreadable prescription. But it's not the first time that poor physician handwriting had made headlines.

In the October 1, 1864 issue of the *San Francisco Morning Call*, famous author Mark Twain wrote the following: continued on page 2

Your medicine cabinet...

Throw away your old medicines safely

As the New Year begins, it's a great time to see if any of your medicines should be discarded because they are too old or no longer needed. On prescription bottles, the label will often tell you when the medicine should be discarded. On over-the-counter medicines and sample medicines, the expiration date (the date it should be discarded) is often printed on the label under "EXP," or stamped without ink into the bottom of a bottle, carton, or the crimp of a tube. For medicines without an expiration date, unless you know you purchased it within the past year, it's best to toss it. As time passes, medicines may lose their effectiveness, especially if they are stored in a medicine cabinet in a warm, moist bathroom. In rare cases, outdated medicines could become toxic. For example, taking expired tetracycline (an antibiotic) can cause serious kidney problems.

In the past, most people flushed old medicines down the toilet. This was done to prevent accidental poisonings of children and animals who may find medicines in the trash. But today, the *Environmental Protection Agency* (EPA) no longer recommends this. Sewage treatment plants may not be able to clean all medicines out of the water. This may harm fish and wildlife. Fortunately, drinking water for humans has rarely been shown to have traces of medicines.

To throw away your medicines safely, check with your local government. Many cities and towns have household hazardous waste facilities where you can bring your old medicines. Or ask your pharmacist about proper disposal in your area. If disposal in regular trash is your best option, follow the steps below to prevent accidental poisonings with children and animals, and to protect your privacy.

- Keep all medicines in their original container with childproof lids attached.
- Mark out anyone's name that may be printed on a prescription container.
- Place liquids in a plastic sealable bag in case it leaks or breaks.
- Put everything inside a sturdy container (like a plain brown box).
- Add a non-toxic but bad tasting product like cayenne pepper to the container.
- Make this container the last thing you put in the garbage can before pick-up.

Source: Boehringer, SK. What's the best way to dispose of medications? *Pharmacist's Letter* 2004; 20(200415).

Lessons in *handwriting*

continued from page 1

"It would be a good thing for the world at large, however unprofessional it might be, if medical men were required by law to write out in full the ingredients named in their prescriptions. Let them adhere to the Latin, or Fejee, if they choose, but discard abbreviations, and form their letters as if they had been to school one day in their lives, so as to avoid the possibility of mistakes on that account."

In the not too distant future, most doctors will be using computers to send prescriptions electronically to the pharmacy. Until then, if your doctor gives you a prescription, check the handwriting. If you can't read it, your pharmacist may not be able to read it, either. Given the large number of medicines with names that look alike, your pharmacist could make a mistake. At best, he must call your doctor to interpret the prescription. Save your pharmacist this extra step by asking your physician for a legible prescription that includes the purpose of the medicine. It's not rude; it's the safe thing to do!

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60 second safety tip

continued from page 1

prescription number, which can be used to call for a refill. To avoid mistakes, some pharmacists will also label the actual medicine container inside the box. If your medicine comes in a box, ask your pharmacist to open it and label the medicine container directly.

■ **Don't connect the tubes.** When you visit someone in the hospital, you may be amazed to see how many tubes are connected to them. Sometimes one of these tubes becomes disconnected. But don't try to be helpful and reattach the tube. You could connect it to the wrong thing and cause serious harm. Many tubes used in the hospital can be connected to each other, even though they don't belong together. For example, several people have died after tubing from a blood pressure machine or an oxygen mask was mistakenly connected to an intravenous tube (which supplies fluid and medicine into the vein). The wrong connections allowed air to enter the vein. These mistakes are easy to make. Most tubes are clear, and they contain either air or clear fluids. The best solution lies with designing tubes so the ones that shouldn't fit together don't. But it may be years before that happens, so always call a nurse immediately to help reconnect any tubing that has become dislodged.

Contact Information

Safe Medicine (ISSN 1550-6282)
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Editors: Judy Smetzer, RN, BSN; Nancy Tuohy, RN, MSN; Michael R. Cohen, RPh, MS, ScD, Russell Jenkins, MD. ISMP, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Email: consumer@ismp.org. To subscribe, visit: www.ismp.org/consumerarticles.